DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To: Pharmacists
All Prescribers
Managed Care Plans

Memorandum No: 05-18 MAA
Issued: April 1, 2005

For More Information, call:
1-800-562-6188

From: Douglas Porter, Assistant Secretary
Medical Assistance Administration

Subject: **Prescription Drug Program: Prior Authorization and Expedited Prior Authorization Changes**

Effective the week of May 2, 2005, and after, the Medical Assistance Administration (MAA) will implement the following changes to MAA's Prescription Drug Program:

- Expedited Prior Authorization (EPA) Additions; and
- Prior Authorization Changes.

Expedited Prior Authorization Additions

Effective the week of May 2, 2005, the following drugs require EPA:

Drug	Code	Criteria
Campral® *(acamprosate sodium)*	041	Diagnosis of alcohol dependency. **Must be used as adjunctive treatment with a Division of Alcohol and Substance Abuse (DASA) state-certified chemical dependency treatment program.** Treatment is limited to 12 months. The patient must also meet all of the following criteria: a) Must have finished detoxification and must be abstinent from alcohol before the start of treatment; b) Must not be a poly-substance abuser; and c) Must be able to clear the drug renally (creatinine clearance greater than 30 ml/min). **Note:** A Campral authorization form [DSHS 13-749(x)] must be completed and kept on file with the pharmacy before the drug is dispensed. To download a copy, go to: http://www1.dshs.wa.gov/msa/forms/eforms.html.

Drug	Code	Criteria
Geodon® IM Injection *(ziprasidone mesylate)*	058	All of the following must apply: a) Diagnosis of acute agitation associated with schizophrenia; b) Patient is 18 years of age or older; and c) Maximum dose of 40mg per day and no more than 3 consecutive days of treatment.
Lunesta™ *(eszopiclone)*	006	Short term treatment of insomnia. Drug therapy is limited to ten in 30 days, after which the patient must be re-evaluated by the prescriber before therapy can continue.
Risperdal Consta® IM Injection *(risperidone microspheres)*	059	All of the following must apply: a) There must be an appropriate DSM IV diagnosis; b) Patient is 18 years of age or older; c) Documented response to oral risperidone monotherapy; d) Documented history of patient noncompliance with oral drug therapy; e) Tolerance to greater than or equal to 2mg/day of oral risperidone; f) Patient is not on concurrent carbamazepine therapy; and g) Maximum dose shall not exceed 50mg or be more frequent than every 2 weeks.
Zyprexa® IM Injection *(olanzapine)*	060	All of the following must apply: a) Diagnosis of acute agitation associated with schizophrenia or bipolar I mania; b) Patient has been evaluated for postural hypotension and no postural hypotension is present before dose is given; c) Patient is 18 years of age or older; and d) Maximum dose of 30mg in a 24 hour period.

Drugs No Longer Requiring Prior Authorization

Drug
Alocril (nedocromil sodium)
Antara (fenofibrate, micronized)
Aranesp (darbepoetin alfa in abumn sol)
Campath (alemtuzumab)
Invirase (saquinavir mesylate)
Lariam (mefloquine HCl)

Drug
Pediatex-D (carbinoxamine maleate/pseudoephedrine) liquid
Selseb (selenium sulfide)
Zylet™ (loteprednol etabonate/tobramycin) ophthalmic suspension
Pediatex-D™ (carbinoxamine maleate/pseudoephedrine) liquid

Billing Instructions Replacement Pages

Attached are replacement pages H.7-H.18 for MAA's *Prescription Drug Program Billing Instructions*.

How can I get MAA's provider issuances?

To obtain MAA's provider numbered memoranda and billing instructions, go to MAA's website at http://maa.dshs.wa.gov (click on the Billing Instructions/Numbered Memoranda or Provider Publications/Fee Schedules link).

To request a free paper copy from the Department of Printing:

- **Go to: http://www.prt.wa.gov/** (Orders filled daily**)** Click on General Store. Follow prompts to Store Lobby → Search by Agency → Department of Social and Health Services → Medical Assistance Administration → desired issuance; **or**

- **Fax/Call:** Dept. of Printing/Attn: Fulfillment at FAX (360) 586-6361/ telephone (360) 586-6360. (Orders may take up to 2 weeks to fill.)

Drug	Code	Criteria
Abilify® *(aripiprazole)*	015	All of the following must apply: a) There must be an appropriate DSM IV diagnosis; and b) Patient is 6 years of age or older.
Accutane® *(isotretinoin)*		Must not be used by patients who are pregnant or who may become pregnant while undergoing treatment. The following conditions must be **absent**: a) Paraben sensitivity; b) Concomitant etretinate therapy; and c) Hepatitis or liver disease.
	001	Diagnosis of severe (disfiguring), recalcitrant cystic acne, unresponsive to conventional therapy.
	002	Diagnosis of severe, recalcitrant acne rosacea in adults unresponsive to conventional therapy.
	003	Diagnosis of severe keratinization disorders when prescribed by, or in consultation with, a dermatologist.
	004	Prevention of skin cancers in patients with xeroderma pigmentosum.
	005	Diagnosis of mycosis fungoides (T-cell lymphoma) unresponsive to other therapies.

Drug	Code	Criteria
Adderall® *(amphetamine/ dextroamphetamine)*	026	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) and the prescriber is an authorized schedule II prescriber.
	027	Diagnosis of narcolepsy by a neurologist or sleep specialist, following documented positive sleep latency testing and the prescriber is an authorized schedule II prescriber.
	087	Depression associated with end stage illness and the prescriber is an authorized schedule II prescriber.
Adderall XR® *(amphetamine/ dextroamphetamine)*	094	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) and all of the following: a) The prescriber is an authorized schedule II prescriber; and b) Total daily dose is administered as a single dose.
Adeks® **Multivitamins**	102	For the treatment of malabsorption conditions, especially those conditions that inhibit the absorption of fat-soluble vitamins (such as cystic fibrosis, steatorrhea, hepatic dysfunction, and cases of HIV/AIDS with malabsorption concern) and all the following: a) Patient is under medical supervision; and b) Patient is not taking oral anticoagulants; and c) Patient does not have a history of or is not at an increased risk for stroke/thrombosis.

Drug	Code	Criteria
Aggrenox® *(aspirin/ dipyridamole)*	037	To reduce the risk of stroke in patients who have had transient ischemia of the brain or completed ischemic stroke due to thrombosis, and all of the following: a) The patient has tried and failed aspirin or dipyridamole alone; and b) The patient has no sensitivity to aspirin.
Altace® *(ramipril)*	020	Patients with a history of cardiovascular disease.
Ambien® *(zolpidem tartrate)*	006	Short term treatment of insomnia. Drug therapy is limited to ten in 30 days, after which the patient must be re-evaluated by the prescriber before therapy can continue.
Angiotensin Receptor Blockers (ARBs)	092	Must have tried and failed, or have a clinically documented intolerance to an angiotensin converting enzyme (ACE) inhibitor. **Atacand**® *(candesartan cilexetil)* **Atacand HCT**® *(candesartan cilexetil/HCTZ)* **Avalide**® *(irbesartan/HCTZ)* **Avapro**® *(irbesartan)* **Benicar**® *(olmesartan medoxomil)* **Cozaar**® *(losartan potassium)* **Diovan**® *(valsartan)* **Diovan HCT**® *(valsartan/HCTZ)* **Hyzaar**® *(losartan potassium/HCTZ)* **Micardis**® *(telmisartan)* **Micardis HCT**® *(telmisartan/HCTZ)* **Teveten**® *(eprosartan mesylate)* **Teveten HCT**® *(eprosartan mesylate/HCTZ)*
Anzemet® *(dolasetron mesylate)*	127	Prevention of nausea or vomiting associated with moderately to highly emetogenic cancer chemotherapy.

Drug	Code	Criteria
Arava® *(leflunomide)*	034	Treatment of rheumatoid arthritis when prescribed by a rheumatologist at a loading dose of 100mg per day for three days and then up to 20mg daily thereafter.
Avinza® *(morphine sulfate)*	040	Diagnosis of cancer-related pain.
Calcium w/Vitamin D Tablets	126	Confirmed diagnosis of osteoporosis, osteopenia or osteomalacia.
Campral® *(acamprosate sodium)*	041	Diagnosis of alcohol dependency. Must be used as adjunctive treatment with a Division of Alcohol and Substance Abuse (DASA) state-certified chemical dependency treatment program. Treatment is limited to 12 months. The patient must also meet all of the following criteria: a) Must have finished detoxification and must be abstinent from alcohol before the start of treatment; b) Must not be a poly-substance abuser; and c) Must be able to clear the drug renally (creatinine clearance greater than 30 ml/min). ☞ **Note:** A Campral authorization form [DSHS 13-749] must be completed and kept on file with the pharmacy before the drug is dispensed. To download a copy, go to: http://www1.dshs.wa.gov/msa/forms/eforms.html.

Drug	Code	Criteria
Clozapine **Clozaril®**	018	All of the following must apply: a) There must be an appropriate DSM IV diagnosis present as determined by a qualified mental health professional; and b) Patient is 17 years of age or older; and c) Must be prescribed by a psychiatrist, neurologist, or psychiatric ARNP with prescriptive authority approved for this drug class, or in consultation with one of the above.
Concerta® *(methylphenidate HCl)*	026	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) and the prescriber is an authorized schedule II prescriber.
Copegus® *(ribavirin)*	010	Diagnosis of chronic hepatitis C virus infection in patients 18 years of age or older. Patient must be on concomitant alpha interferon or pegylated alpha interferon therapy (not to be used as monotherapy).
Coreg® *(carvedilol)*	057	Diagnosis of congestive heart failure.
Dexedrine® *(D-amphetamine sulfate)*		See criteria for Adderall®.
Dextrostat® *(D-amphetamine sulfate)*		See criteria for Adderall®.
Duragesic® *(fentanyl)*	040	Diagnosis of cancer-related pain.

Drug	Code	Criteria
Enbrel® *(etanercept)*	017	Treatment of rheumatoid arthritis or ankylosing spondylitis when prescribed by a rheumatologist up to 50mg subcutaneously per week for patients who have had an inadequate response to one or more Disease Modifying Anti Rheumatoid Drug (DMARD).
	024	Treatment of psoriatic arthritis when prescribed by a rheumatologist or dermatologist up to 50mg subcutaneously per week for patients who have had an inadequate response to one or more DMARD.
	025	Treatment of plaque psoriasis in patients 18 years of age and older when prescribed by a rheumatologist or dermatologist. Dose not to exceed 50mg subcutaneously twice weekly for the first three months of therapy and not to exceed 50mg weekly thereafter.
Fazaclo® *(clozapine)*	012	All of the following must apply: a) There must be an appropriate DSM IV diagnosis present as determined by a qualified mental health professional; and b) Patient is 18 years of age or older; and c) Must be prescribed by a psychiatrist, neurologist, or psychiatric ARNP with prescriptive authority approved for this drug class, or in consultation with one of the above; and d) Must have tried and failed generic clozapine.
Focalin® *(dexmethylphenidate HCl)*		See criteria for Concerta®.

Drug	Code	Criteria
Geodon® *(ziprasidone HCl)*	046	All of the following must apply: a) There must be an appropriate DSM IV diagnosis; and b) Patient is 6 years of age or older.
		Note: Because Geodon® prolongs the QT interval (< Seroquel® > Risperdal® > Zyprexa®), it is contraindicated in patients with a known history of QT prolongation (including a congenital long QT syndrome), with recent acute myocardial infarction, or with uncompensated heart failure; and in combination with other drugs that prolong the QT interval.
Geodon® IM Injection *(ziprasidone mesylate)*	058	All of the following must apply: a) Diagnosis of acute agitation associated with schizophrenia; b) Patient is 18 years of age or older; and c) Maximum dose of 40mg per day and no more than 3 consecutive days of treatment.
Glycolax Powder® *(polyethylene glycol)*	021	Treatment of occasional constipation. Must have tried and failed a less costly alternative.
Humira Injection® *(adalimumab)*	028	Treatment of rheumatoid arthritis when prescribed by a rheumatologist for patients who have tried and failed one or more DMARD. Dose not to exceed 40mg subcutaneously every two weeks if patient is also receiving methotrexate, or up to 40mg subcutaneously every week if patient is not receiving methotrexate concomitantly.
Infergen® *(interferon alphcon-1)*	134	Treatment of chronic hepatitis C in patients 18 years of age and older with compensated liver disease who have anti-HCV serum antibodies and/or presence of HCV RNA.

Drug	Code	Criteria
Intron A® *(interferon alpha-2b recombinant)*	030	Diagnosis of hairy cell leukemia in patients 18 years of age and older.
	031	Diagnosis of recurring or refractory condyloma acuminate (external genital/perianal area) for intralesional treatment in patients 18 years of age and older.
	032	Diagnosis of AIDS-related Kaposi's sarcoma in patients 18 years of age and older.
	033	Diagnosis of chronic hepatitis B in patients 1 year of age and older.
	107	Diagnosis of malignant melanoma in patients 18 years of age and older.
	109	Treatment of chronic hepatitis C in patients 18 years of age and older.
	135	Diagnosis of follicular non-Hodgkin's lymphoma in patients 18 years of age and older.
Kadian® *(morphine sulfate)*	040	Diagnosis of cancer-related pain.
Kineret Injection® *(anakinra)*	029	Treatment of rheumatoid arthritis when prescribed by a rheumatologist for patients 18 years of age and older who have tried and failed one or more DMARD. Daily dose not to exceed 100mg subcutaneously.
Kytril® *(granisetron HCl)*	127	Prevention of nausea or vomiting associated with moderately to highly emetogenic cancer chemotherapy.
	128	Prevention of nausea or vomiting associated with radiation therapy.

Drug	Code	Criteria
Lamisil® *(terbinafine HCl)*		Treatment of onychomycosis for up to 12 months is covered if patient has one of the following conditions:
	042	Diabetic foot;
	043	History of cellulitis secondary to onychomycosis and requiring systemic antibiotic therapy;
	051	Peripheral vascular disease; **or**
	052	Patient is immunocompromised.
Levorphanol	040	Diagnosis of cancer-related pain.
Lotrel® *(amlodipine besylate/benazepril)*	038	Treatment of hypertension as a second line agent when blood pressure is not controlled by any: a) ACE inhibitor alone; or b) Calcium channel blocker alone; or c) ACE inhibitor and a calcium channel blocker as two separate concomitant prescriptions.
Lunesta™ *(eszopiclone)*	006	Short term treatment of insomnia. Drug therapy is limited to ten in 30 days, after which the patient must be re-evaluated by the prescriber before therapy can continue.
Marinol® *(dronabinol)*	035	Diagnosis of cachexia associated with AIDS
	036	Diagnosis of cancer and failure of all other drugs to adequately treat nausea and vomiting related to radiation or chemotherapy.
Metadate CD® *(methylphenidate HCl)*		See criteria for Concerta®.

Drug	Code	Criteria
Miralax® *(polyethylene glycol)*		See criteria for Glycolax Powder®
Naltrexone		See criteria for ReVia®.
Nephrocaps®	096	Treatment of patients with renal disease.
Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)	141	An absence of a history of ulcer or gastrointestinal bleeding.

Nephro-FER® *(ferrous fumarate/ folic acid)*
Nephro-Vite® *(vitamin B comp W-C)*
Nephro-Vite RX® *(folic acid/vitamin B comp W-C)*
Nephro-Vite+FE® *(fe fumarate/FA/ vitamin B comp W-C)*
Nephron FA® *(fe fumarate/doss/ FA/B comp & C)*

Ansaid® *(flurbiprofen)*
Arthrotec® *(diclofenac/misoprostol)*
Bextra® *(valdecoxib)*
Cataflam® *(diclofenac)*
Celebrex® *(celecoxib)*
Clinoril® *(sulindac)*
Daypro® *(oxaprozin)*
Feldene® *(piroxicam)*
Ibuprofen
Indomethacin
Lodine®, Lodine XL® *(etodolac)*
Meclofenamate
Mobic® *(meloxicam)*
Nalfon® *(fenoprofen)*
Naprelan®, Naprosyn® *(naproxen)*
Orudis®, Oruvail® (ketoprofen)
Ponstel® *(mefenamic acid)*
Relafen® *(nabumetone)*
Tolectin® *(tolmetin)*
Toradol® *(ketorolac)*
Voltaren® *(diclofenac)*

Drug	Code	Criteria
Oxandrin® *(oxandrolone)*		Before any code is allowed, there must be an absence of all of the following: a) Hypercalcemia; b) Nephrosis; c) Carcinoma of the breast; d) Carcinoma of the prostate; and e) Pregnancy.
	110	Treatment of unintentional weight loss in patients who have had extensive surgery, severe trauma, chronic infections (such as AIDS wasting), or who fail to maintain or gain weight for no conclusive pathophysiological cause.
	111	To compensate for the protein catabolism due to long-term corticosteroid use.
	112	Treatment of bone pain due to osteoporosis.
OxyContin® *(oxycodone HCI)*	040	Diagnosis of cancer-related pain.
Parcopa® *(carbidopa/levodopa)*	049	Diagnosis of Parkinson's disease and one of the following: a) Must have tried and failed generic carbidopa/levodopa; or b) Be unable to swallow solid oral dosage forms.
PEG-Intron® *(peginterferon alpha 2b)*	109	Treatment of chronic hepatitis C in patients 18 years of age or older.
Pegasys® *(peginterferon alpha-2a)*	109	Treatment of chronic hepatitis C in patients 18 years of age or older.
Plavix® *(clopidogrel bisulfate)*	116	When used in conjunction with stent placement in coronary arteries. Supply limited to 9 months after stent placement.
	136	For use in patients with atherosclerosis documented by recent myocardial infarction, recent stroke, or established peripheral artery disease and have failed aspirin. A patient that is considered an aspirin failure has had an atherosclerotic event (MI, stroke, intermittent claudication) after the initiation of once-a-day aspirin therapy.
Pravachol® *(pravastatin sodium)*	039	Patient has a clinical drug-drug interaction with other statin-type cholesterol-lowering agents.
Prevacid® **Solutab** *(lansoprazole)*	050	Inability to swallow oral tablets or capsules.
Pulmozyme® *(dornase alpha)*	053	Diagnosis of cystic fibrosis and the patient is 5 years of age or older.
Rebetol® *(ribavirin)*		See criteria for Copegus®.
Rebetron® *(ribaviron/interferon alpha-2b, recombinant)*	008	Treatment of chronic hepatitis C in patients with compensated liver disease who have relapsed following alpha interferon therapy.
	009	Treatment of chronic hepatitis C in patients with compensated liver disease.
Remicade Injection® *(infliximab)*	022	Treatment of rheumatoid arthritis in combination with methotrexate when prescribed by a rheumatologist in those patients who have had an inadequate response to methotrexate alone.

Drug	Code	Criteria
	023	Treatment of Crohn's disease when prescribed by a gastroenterologist in those patients who have tried and failed conventional therapy.
Rena-Vite® **Rena-Vite RX**® *(folic acid/vit B comp W-C)*	096	Treatment of patients with renal disease.
ReVia® *(naltrexone HCl)*	067	Diagnosis of past opioid dependency or current alcohol dependency. Must be used as adjunctive treatment within a state-certified chemical dependency treatment program. For maintenance of opioid-free state in a detoxified person, treatment may be started only after a minimum of 7-10 days free from opioid use. Treatment period must be limited to 12 weeks or less, and the patient must have an absence of all of the following: a) Acute liver disease; and b) Liver failure; and c) Pregnancy.
		☞ **Note:** A ReVia® (Naltrexone) Authorization Form [DSHS 13-677] must be on file with the pharmacy before the drug is dispensed. **To download a copy, go to:** http://www1.dshs.wa.gov/msa/forms/eforms.html
Ribavirin		See criteria for Copegus®.
Risperdal® *(risperidone)*	054	All of the following must apply: a) There must be an appropriate DSM IV diagnosis; and b) Patient is 6 years of age or older.

Drug	Code	Criteria
Risperdal Consta® IM Injection *(risperidone microspheres)*	059	All of the following must apply: a) There must be an appropriate DSM IV diagnosis; b) Patient is 18 years of age or older; c) Documented response to oral risperidone monotherapy; d) Documented history of noncompliance; e) Tolerance to greater than or equal to 2mg/day of oral risperidone; f) Patient is not on concurrent carbamazepine therapy; and g) Maximum dose shall not exceed 50mg or be more frequent than every 2 weeks.
Ritalin LA® *(methylphenidate HCl)*		See criteria for Concerta®.
Roferon-A® *(interferon alpha-2a recombinant)*	030	Diagnosis of hairy cell leukemia in patients **18** years of age and older.
	032	Diagnosis of AIDS-related Kaposi's sarcoma in patients **18** years of age and older.
	080	Diagnosis of chronic phase, Philadelphia chromosome (Ph) positive chronic myelogenous leukemia (CML) when treatment started within one year of diagnosis.
	109	Treatment of chronic hepatitis C in patients **18** years of age and older.
Seroquel® *(quetiapine fumarate)*		See criteria for Risperdal®.
Sonata® *(zaleplon)*		See criteria for Ambien®.

Drug	Code	Criteria
Soriatane® *(acitretin)*	064	Treatment of severe, recalcitrant psoriasis in patients **16** years of age and older. Prescribed by, or in consultation with, a dermatologist, and the patient must have an **absence** of all of the following: a) Current pregnancy or pregnancy which may occur while undergoing treatment; and b) Hepatitis; and c) Concurrent retinoid therapy.
Sporanox® *(itraconazole)*		Must not be used for a patient with cardiac dysfunction such as congestive heart failure.
	047	Treatment of systemic fungal infections and dermatomycoses.
		Treatment of onychomycosis for up to 12 months is covered if patient has one of the following conditions:
	042	Diabetic foot;
	043	History of cellulitis secondary to onychomycosis **and** requiring systemic antibiotic therapy;
	051	Peripheral vascular disease; **or**
	052	Patient is immunocompromised.
Strattera® *(atomoxetine HCI)*	007	Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD).

Drug	Code	Criteria
Suboxone® *(buprenorphine/naloxone)*	019	Before this code is allowed, the patient must meet <u>all</u> of the following criteria. The patient: a) Is **16** years of age or older; b) Has a <u>DSM-IV-TR</u> diagnosis of opioid dependence; c) Is psychiatrically stable or is under the supervision of a mental health specialist; d) Is not abusing alcohol, benzodiazepines, barbiturates, or other sedative-hypnotics; e) Is not pregnant or nursing; f) Does not have a history of failing multiple previous opioid agonists treatments and multiple relapses; g) Does not have concomitant prescriptions of azole antifungal agents, macrolide antibiotics, protease inhibitors, phenobarbital, carbamazepine, phenytoin, and rifampin, unless dosage adjusted appropriately; and h) Is enrolled in a state-certified chemical dependency treatment program. **Limitations:** • No more than 14-day supply may be dispensed at a time; • Urine drug screens for benzodiazepines, amphetamine/ methamphetamine, cocaine, methadone, opiates, and barbiturates must be done before each prescription is dispensed. <u>The prescriber must fax the pharmacy with confirmation that the drug screen has been completed to release the next 14-day supply. The fax must be retained in the pharmacy for audit purposes;</u> • Liver function tests must be monitored periodically to guard against buprenorphine-induced hepatic abnormalities; and

Drug	Code	Criteria
		• Clients may receive up to 6 months of buprenorphine treatment for detoxification and stabilization.
		☞ **Note:** A Buprenorphine-Suboxone Authorization Form (DSHS 13-720) must be on file with the pharmacy before the drug is dispensed. **To download a copy, go to:** http://www1.dshs.wa.gov/msa/forms/eforms.html
Symbyax® *(olanzapine/ fluoxetine HCl)*	048	All of the following must apply: a) Diagnosis of depressive episodes associated with bipolar disorder; and b) Patient is **6** years of age or older.
Talacen® *(pentazocine HCl/ acetaminophen)* **Talwin NX®** *(pentazocine/naloxone)*	091	Patient must be **12** years of age or older and has tried and failed two NSAIDs or failed one other narcotic analgesic and is allergic or sensitive to codeine.
Vancomycin oral	069	Diagnosis of clostridium difficile toxin and the patient has failed to respond after two days of metronidazole treatment or the patient is intolerant to metronidazole.
Vitamin ADC Drops	093	The child is breastfeeding and: a) The city water contains sufficient fluoride to contraindicate the use of Trivits w/Fl; and b) The child is taking medications which require supplemental Vitamin D, as determined medically necessary by the prescriber and cannot be obtained by any other source.
Vitamin E	105	Confirmed diagnosis of tardive dyskinesia or is clinically necessary for Parkinsonism and all of the following: a) Caution is addressed for concurrent anticoagulant treatment; and b) Dosage does not exceed 3,000 IU per day.
Wellbutrin SR and XL® *(bupropion HCl)*	014	Treatment of depression.
Xopenex® *(levalbuterol HCl)*	044	All of the following must apply: a) Patient is 6 years of age or older; and b) Diagnosis of asthma, reactive airway disease, or reversible airway obstructive disease; and c) Must have tried and failed racemic generic albuterol; and d) Patient is not intolerant to beta-adrenergic effects such as tremor, increased heart rate, nervousness, insomnia, etc.
Zelnorm® *(tegaserod hydrogen maleate)*	055	Treatment of constipation dominant Irritable Bowel Syndrome (IBS) in women when the patient has tried and failed at least two less costly alternatives.
	056	Chronic constipation when the patient has tried and failed at least two less costly alternatives.
Zofran® *(ondansetron HCl)*		See criteria for Kytril®.

Drug	Code	Criteria
Zometa® *(zoledronic acid)*	011	Diagnosis of hypercalcemia associated with malignant neoplasms with or without metastases; or multiple myeloma; or bone metastases of solid tumors.
Zyprexa® **Zyprexa Zydis**® *(olanzapine)*		See criteria for Risperdal®.
Zyprexa® **IM Injection** *(olanzapine)*	060	All of the following must apply: a) Diagnosis of acute agitation associated with schizophrenia or bipolar I mania; b) Patient has been evaluated for postural hypotension and no postural hypotension is present before dose is given; c) Patient is 18 years of age or older; and d) Maximum dose of 30mg in a 24 hour period.
Zyvox Injectable® *(linezolid)*	013	Treatment of vancomycin resistant infection.
Zyvox Oral® *(linezolid)*	013	Treatment of vancomycin resistant infection.
	016	Outpatient treatment of methacillin resistant staph aureaus (MRSA) infections when IV vancomycin is contraindicated, such as: a) Allergy; or b) Inability to maintain IV access.

Limitation extensions (LE)

What is a Limitation Extension?

A Limitation Extension (LE) is a request to exceed stated limitations or other restrictions on covered services. LE is a form of prior authorization. MAA evaluates a request for covered services that are subject to limitations or restrictions, and approves such services beyond those limitations or restrictions when medically necessary, under the standard for covered services in WAC 388-501-0165. Providers must be able to verify that it is medically necessary to provide more units of prescription drugs than allowed in MAA's billing instructions and Washington Administration Code (WAC).

Requests for limitation extensions must be appropriate to the client's eligibility and/or program limitations. Not all eligibility groups cover all services.

How do I get LE authorization?

Limitation extensions may be requested by calling MAA's Drug Utilization and Review at 1-800-848-2842.

Limitation Extensions DO NOT APPLY to noncovered prescription drugs.
See page C.4 for information on Exception to Rule.

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